SOLVING THE URBAN DILEMMA IN HEALTH CARE: MORE POVERTY, GREATER DEMAND FOR PUBLIC SERVICES, REDUCED FINANCIAL RESOURCES, AND FRAGMENTATION OF SERVICES

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WHEN I initially was invited here, I thought that I was invited as one who was not part of the field and that I should therefore be able to say those things that the liberal medical establishment might not be willing to say in public. I find, however, forthright discussion at this meeting, and most of the points that I had thought to make have already been clearly made. I am pleased by this, particularly in light of the fact that, during the past couple of weeks, I have made a number of speeches on both coasts of the country and have found myself in unproductive argument with other speakers. It is rather comforting to come to a place where the kind of ideas that I have been developing turn out to be the ideas of many other people.

Unfortunately, I tend to have a skeptical attitude. And when I find such a high degree of agreement, I wonder whether we have the right audience—or perhaps our agreement is spurious—we don't really understand each other. Or the reason we agree is that the problems to which we address ourselves have developed beyond our analysis; our consensus may be at a level that is not quite the level at which the problems now must be addressed. I feel the latter may be true here.

It may well be that while we are concerned about the problems of the poor, one has to be much more fundamentally attuned to the general problems of medical care in the United States, raising the basic issue of the effectiveness of medical care indicated in Dr. George G. Reader's study describing limited differences between recipients and

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nonrecipients of medical care.

I do not intend to address myself to the underlying effectiveness questions, but to stick with the poverty-type questions. My role will be to analyze some of the same materials presented by the other speakers in a somewhat different way. I hope that my alternative formulations will not turn out to be a solipsistic system.

I think we are here at this meeting as part of the attention that has finally been focused in the United States on long-neglected issues. Through the postwar period, we were elated to avoid a depression. We were delighted by the rising gross national product and increasing levels of living. We became seduced by our affluence and fell into a state of shock at our affluence, a euphoria of growth. What has occurred in the 1960's is that we have begun to question what is happening in the United States, attempting to understand, to a much greater extent than we have, demographic and social class changes in the country. The attention paid to poverty is a reflection, I think, of the recognition of the continuing significance of social class in the United States.

Demographic Changes

First, let me point out briefly some of the demographic factors that propel our attention today to issues of poverty, particularly of urban poverty. One is the obvious fact that the United States is rapidly becoming a heavily urbanized country. It has not been recognized that the United States was slow in becoming urbanized. It was not until between 1910 and 1920 that over 50 per cent of people in the United States lived in communities of 2,500 or more. In recent years there has been an acceleration of urbanization and metropolitanization with the expectation that, within a few years, three quarters of the population will live in cities or metropolitan districts.

A second factor is the increasing importance of the aged in the United States, a fact that was not fully understood by Senator Barry Goldwater when he campaigned in New Hampshire in 1964 and advocated the abolition of social security. One of eight adults in the United States is "aged" (over 65) at the present time. Moreover, if you take the aged population who are poor, half of them became poor only after they were aged. That is a heavy social price for being old. (That half figure, I must add, is an estimate I have concocted by playing around with the figures. We do not have these data available.)

Social Class

Urbanization and the importance of the aged are important demographic change factors in life in the United States. Sitting on top of them and focusing our attention has been the social class or the social stratification forces in our society. Despite the growing average level of income in the United States, some groups have fallen behind or remained behind the general economic advance of society. We have called these groups, finally, the "poor." We are now talking about poverty as we begin to recognize that sizeable groups are falling behind the general advance of society.

Feeling poverty has been the long-term disadvantage of Negroes in the United States. Poor Negroes are piling up particularly in large cities, and large cities are inadequately prepared to deal with the problems of poverty and of race today.

On top of this we have the phenomenon of inequality, tied to the problem of poverty but somewhat independent of it. I think inequality is going to become more significant politically in this country. I think there will be increasing recognition that our agenda is not only to bring the poor up to a certain level in medical care or in housing or in income, but to reduce the gap between the poor and the rest of society. To a large extent we are trying to change the character of the social class structure in the United States; that is implied in trying to change the gaps between groups. We are not just trying to get people into certain niches. We are also trying to reduce some of the disparities that have developed over time in the United States. You heard today about some of the gaps in medical care that have developed in the United States.

As we move to reduce the gaps, I think we shall also be concerned with improving quality. The phases of reducing inequality and of improving quality are in different relationships at various times. They compete for priority—is general advance more important than advance for a specific group? At the moment, the essential emphasis is upon reducing the gaps that have developed in society in the United States.

The New Standard of Living

What has been happening in our society, as in most other industrial societies, is that the educational and social services have become an important component of one's level of living. A whole array of activities, many of them outside the market, some, such as medicine, still

largely in the market, affect the command over resources that characterize a style of life. We can see the importance of these new forms of income when we look at the wage bill in the United States and discover that over 20 per cent of all wage expenditures in this country go for fringe benefits. This proportion is obviously going to increase in coming years.

When we currently talk about health, we are talking about an issue of great public significance, for health measures are now an important ingredient—to a much greater extent than ever before—in one's feeling about his standard of living. A person who has a high income but gets poor medical care has suffered a diminution in his standard of life as a result of the inadequate medical care.

To a large extent, individuals cannot get good health and educational services individually. They can get them only collectively. It is hard to buy good medical care where it does not exist. It is hard to buy good education where an effective educational system does not exist.

Consequently, more and more of the issues that arise become public issues subject to public criteria of judgment. Consequently, the medical system in this country will increasingly be subjected to *public evaluation of performance.* No longer will it be possible for a medical profession to believe that it has an exclusive right to judge its own performance. As health becomes more significant in terms of expenditures on it and of people's expectations of the returns on these expenditures, it will become an activity appraised by public criteria.

To some extent, medicine has the form of a public utility in private hands. It is in a tensionful position because of the peculiar changes now taking place. Many services are borne outside the usual market relationships but have an important impact upon the nature of income and well-being of individuals. Obviously, new kinds of partnerships may develop. Group medical care may become more significant but, since I have been reading about group medical care for about 30 years (I was a debater on socialized medicine when I was in high school), I have a doubtful conviction that group medical care is going to come to the fore. I think there will be other kinds of potential partnerships that will become more significant than they have been in the past.

We have heard in this panel and from Professor Eveline M. Burns some indication of the essential goals involved in medical care today for the poor. One that has been emphasized a number of times this after-

noon has been to decrease the fragmentation that now exists in medical care (Miss Lisbeth Bamberger spoke of the one-door type of service). We are moving to much greater effort to build coherence in the health system and to wipe out the differentiation that now exists between public and private care. New kinds of arrangements between the voluntary and federal government sectors will probably emerge to a much greater extent than we have seen. Coupled with this will be the effort to produce delivery systems that really deliver and that deliver to the most poor.

Most programs that attempt to deal with the poor tend to cream. They take those of the poor most easy to deal with and neglect those at the bottom. The history of our social welfare measures is that we have almost always creamed. We have consciously or unconsciously selected the most amenable to our procedures, practices, and outlook. Later, we are horrified to discover that there is an underclass that we did not touch.

Today the underclass is being publicized and spotlighted. It will become increasingly a public issue whether or not this underclass gets effective medical care and attention. Our effort will be to deliver systems of effective medical care without stigma.

Threaded through our attention to the underclass, I predict, will be an increasing emphasis upon prevention on a greater scale than we have ever imagined in this country. Obviously, if we begin to realize that nutrition and other factors seem to have the significance that they do, we shall have to rethink the kinds of procedures that are useful.

I think we are going to have to be concerned, as Lee Bamberger has indicated, not only with the quality of service but with the control of the services. I think the motto that is going to develop in the society of the United States with the great expansion of social and educational services is that of "No services without representation." As services begin to be considered as quasi or fully public utilities in our country, more and more of the recipients will attempt to change their relationsip to the services. The recipients will attempt to have some control over this increasingly important component of our standard of life. I suspect that "*No services without representation*" will become a growingly significant part of the development of legal rights in the broadest sense. This slogan is part of the demands for democratization and humanization of bureaucracy that are now being raised in a variety of

forms in the poverty war, in welfare rights, in the courts, and in a variety of other activities in our country.

Obviously, for the developments that we are talking about, more public money will be necessary. It is clear that the effect of the poverty war, if expanded, will largely be to bail out cities. Just as the New Deal bailed out states, the poverty war is bailing out cities. More and more federal money will be needed to provide the kinds of care both in health and other fields that is desired today. The expectational level has gone up remarkably.

I think we are going to have to talk, as we get additional funds, about the performance that attaches to it. We are going to be concerned with evaluation of performance, of monitoring and auditing performance, to a much greater extent than ever before. The medical industry in the United States will have to recognize the significance of independent ways of auditing, inspecting, monitoring, and evaluating services. The strain of development that we are moving toward will be to provide more and more movement toward accountability and to crisscross this sector with another axis that attempts to try to assert public criteria and public judgment about the effectiveness of performance.

I should like to add one note on new personnel. It seems to me that we must accept the fact, dreadful as it may be to many, that the expansion in demand for social and educational services in the United States makes obsolete the conventional way of producing practitioners. By the conventional way of processing and credentialing people today in the United States, it will be literally impossible to provide services to the rising population of this country at the points where they are needed. It is clear we are not going to get social workers to help in medical practice because there are not enough social workers for conventional social work practices. This shortage goes across the board.

We are faced with a professional manpower crisis, requiring a whole reorientation of "professionalism" and professional responsibilities. I have much to say on that, but I shall content myself with one point. I think the *future task of the well-trained will be to make it possible for less-trained people to perform adequately*. Professional development in this country should change. The professionals will not be primarily performing direct client service but making it possible for less-trained people to perform such services. A distinctly secondary task of the pro-

fessional will be to deal with acute difficult cases that cannot be dealt with by the less-trained persons.

We must begin to be reoriented toward the need for professional change, because of the tremendous increase in demand and the inadequacy of the present credentialing system for increasing the supply of professionals. Shoring up old-line professionalism by insisting on higher and higher credentials cannot meet the social responsibilities of today.

We are at a point, obviously, of great change in the United States. We are recognizing what we have ignored—for some time—the sweeping changes that have occurred and the new expectations that have arisen. Medicine, I think, is going to be one of the arenas of great controversy, because it has long been under private control with a private enterprise mentality. It is going to be challenged in terms not only of control but also in terms of its effectiveness, principally among the poor. In the challenge, issues will be raised about the effectiveness of the medical industry in providing adequate medical care for all.